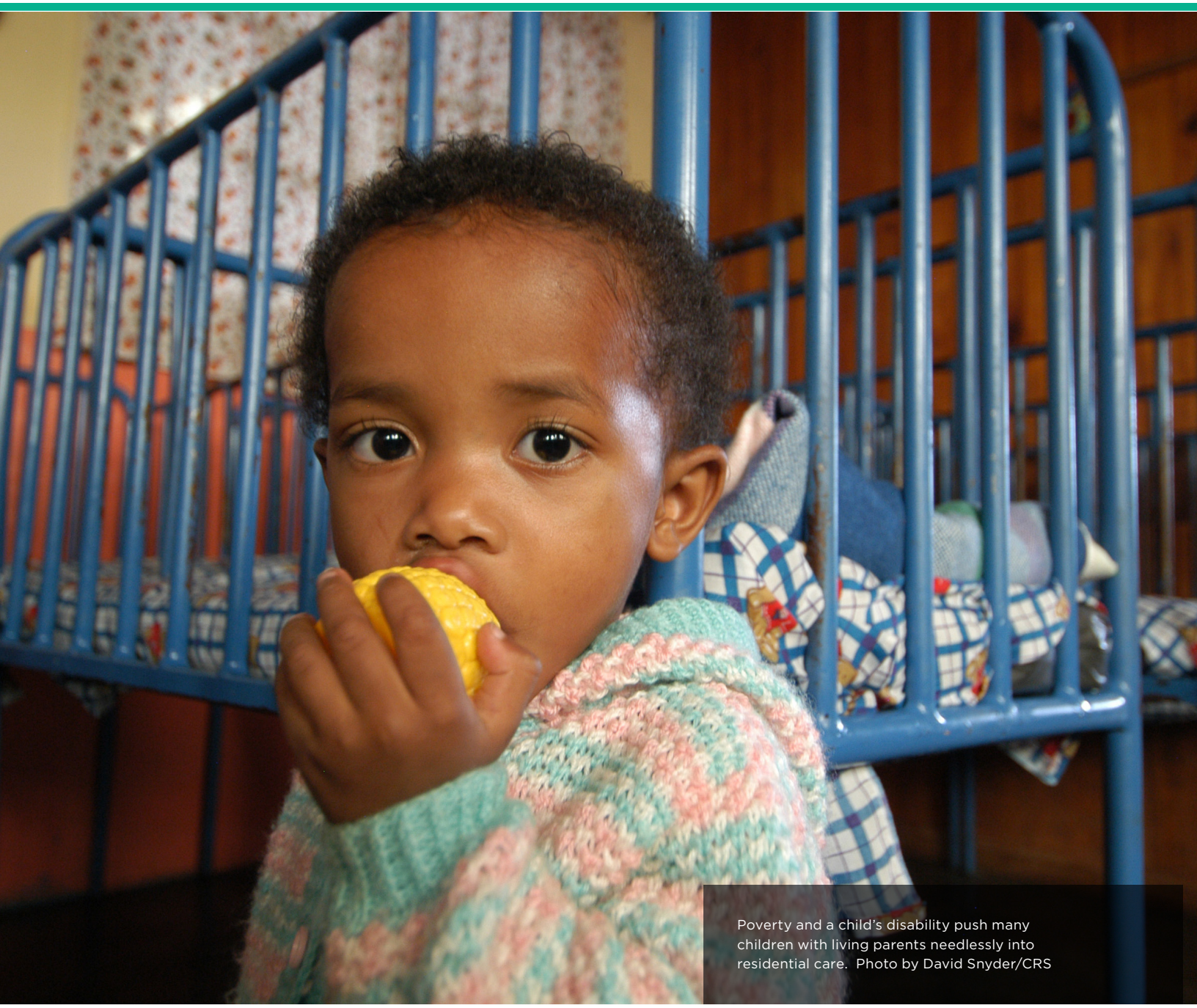

Poverty and a child's disability push many children with living parents needlessly into residential care. Photo by David Snyder/CRS

Finding Families

THE STATE OF RESIDENTIAL CARE FOR CHILDREN AND IMPLICATIONS FOR HUMAN DEVELOPMENT: A RESEARCH REVIEW

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"It has been more than 80 years since researchers in child psychology first documented developmental delays among children separated from family environments and placed in orphanages or other institutions." [1]

Despite decades of rigorous research in a wide array of contexts, evidence illustrates that institutionalization i.e., placement in long-term residential care, also referred to as orphanages, negatively impacts the cognitive, physical and social development of children. Research also shows that the effects are intensified the longer a child is in care and the younger the child is at the time of placement. In some countries, residential care is experiencing exponential growth despite the evidence illustrating that it is harmful to children.

This review is a summary of the literature, from multiple disciplines, on residential child care and its deleterious effects on children. It also points towards a way forward, however, underscoring the need to move definitively away from placement in residential care as a first response and instead focus efforts on prevention of family separation and provision of family-based and supportive community environments.

Despite the challenges that children in residential care face, one theme that emerges is the profound resiliency of children once removed from residential care. Children demonstrate an extraordinary ability to rebound from early obstacles, while adoption and family-centered alternatives have proven far more effective at safeguarding the rights and well-being of children, further adding to the impetus behind moving past residential care except in short-term emergency situations when no safe options with family members exist.

Children demonstrate an extraordinary ability to rebound from early obstacles, while adoption and family-centered alternatives have proven far more effective at safeguarding the rights and well-being of children.

INTRODUCTION

Long-term residential care of children is a more complex phenomenon than it appears superficially, defying simple assumptions. Firstly, the absolute number of children in residential care globally remains unclear. In 2009, UNICEF documented two million institutionalized children based on available data. It warned then that these numbers "severely underestimate" the scale of childhood institutionalization (UNICEF 2009). Indeed, the UN's *World Report on Violence Against Children* estimates that eight million children are institutionalized, again cautioning that this is likely a low figure (Pinheiro 2006).

In 2017, UNICEF compiled data from 140 countries before concluding that at least 2.7 million children live in residential care. It emphasized again, however, that these numbers are "likely just the tip of the iceberg" and that gaps in data collection and accuracy hamper more precise figures, and almost certainly underestimate the reality (Petrowksi, Cappa and Gross 2017).

One reason numbers are so vague is the proliferation of unregistered institutions. Country reports from Ghana to Kyrgyzstan, for instance, acknowledge the prevalence of unregistered facilities and undocumented children that significantly exceed official registers (Child Frontiers Ltd. 2011; UNICEF/ Kyrgyz Republic 2012). In Kyrgyzstan, for instance, a comprehensive research project was planned based on 71 known institutions, but the research itself revealed a total of 117.

1 A.E. Berens & C.A. Nelson, C. A. (2015). "The science of early adversity: is there a role for large institutions in the care of vulnerable children?" The Lancet, p.1 (See: http://faithtoaction.org/wp-content/uploads/2013/09/14TL0649_Berens.pdf)

Photo by Karen Kasmauski for CRS

Ultimately, it is at-risk or vulnerable youth—whether from conflict, poverty, a disability, or neglect—who are most susceptible to residential care, but whose vulnerability is only further compounded by residential care itself.

What drives children into long-term residential care is similarly opaque. There is no clear link, for example, between orphanhood and residential care. Of the 151 million orphans identified by UNICEF in 2011,[2] most remain in family care (UNICEF 2013). In certain settings, most notably sub-Saharan Africa, over 90 percent of orphans who lost both parents (to AIDS, in this study) transitioned into care by extended family, or "kinship" care (Monasch and Boerma 2004). That is the positive news. However, multiple studies reveal that an overwhelming majority of children in long-term residential care have at least one living parent. A 2003 study of 33 European countries revealed that 96% of institutionalized children had one or more living parent (Browne et al. 2005). Csáky (2009) reports that across each Africa, Asia, Central and Eastern Europe and the former Soviet Union, anywhere from 45% (Afghanistan) to 98% (Central and Eastern Europe) of children in institutional care had at least one parent still alive. Research, in fact, has consistently demonstrated that most children in residential care are not orphans (Better Care Network 2017; Williamson and Greenberg 2010).

Poverty, and its effects, underlies most cases in which a child with a parent is placed in residential care. Better Care Network (2017) reviewed national level studies from Africa and identified poverty as one key driver, as well as violence, abuse, neglect and the "pulling effect" of institutions themselves, which is examined in greater detail later. Indeed, under extremely difficult circumstances both parents and governments might find residential care the easiest option, with the hope among parents that their children will receive an education and better care, though this is frequently not the case (Save the Children UK 2009).

2 UNICEF and global partners define an orphan as a child who has lost one or both parents. (See: https://www.brandeis.edu/investigate/adoption/orphan-statistics.html)

THE STATE OF THE ART IN CHILDHOOD INSTITUTIONALIZATION RESEARCH

CHILDHOOD DEVELOPMENT

Studies in the fields of psychology and pediatrics have found consistent evidence linking placement in long-term residential care with downward pressures on childhood health and development. One recent publication (Berens and Nelson 2015) reviews a large number of studies, highlighting the types and degree of harmful effects that institutionalization creates on children, including negative cognitive, physical, and social effects. These results are examined in this section.

Much of the literature, we caution, stems from research that has followed children adopted from especially depriving Romanian orphanages. These are rigorous studies, but results may be limited in their generalizability. That said, this desk review aims to include work from across the globe, and various contexts. On the one hand, evidence is largely consistent across contexts, underscoring the risk to children posed by long-term residential care. On the other hand, and crucially, evidence is equally compelling that the worst effects may be mitigated if a child is removed from care early, and instead placed in a nurturing, interactive and/or family setting.

COGNITIVE FUNCTIONING

A multitude of studies examine the effects of institutionalization on cognitive development and cognitive functioning. Van Ijzendoorn, Luijk and Juffer (2008) conducted a meta-analysis of 42 studies, covering 3888 children in 19 countries. The authors examined the intelligence quotient (IQ) of children (and development quotient [DQ] for infants) in institutionalized versus family-based settings, the findings were stark. Mean IQ of institutionalized children was a full standard deviation lower than that of age-matched controls in a family-setting.

Crucially, the same study highlights how the timing and subsequent duration of institutionalization affects outcomes as well. Children placed in residential care between birth and 12 months of age, the authors observe, had statistically significant IQ deficits compared with their family-based peers, which was a much more pronounced difference than when comparing children placed in institutions after 12 months of age with their family-based peers. Children removed from residential care early, in other words, are spared the worst of the negative effects of residential care, at least with respect to IQ/DQ.

This last observation is bolstered by the results of the 2007 English-Romanian Adoptee (ERA) follow-up study (Rutter, Beckett, Castle, et al. 2007). This study follows the progress over time of Romanian adoptees from institutions of especially poor quality, and was designed intentionally to capture the effects of institutional deprivation on childhood development. Romanian children adopted by UK families were studied both as a group over time, and in comparison to within-UK adoptees who had not spent time in depriving institutions.

The Romanian adoptees had "substantially lower" IQ than non-institutionalized adoptees. However, these differences washed out almost entirely by age eleven *among those children who were adopted before six months of age.* These children, despite the severity of deprivation experienced in the first few months of life, demonstrated a remarkable rate of catch-up in IQ and psychological functioning to non-institutionalized peers following adoption, especially between the ages of four and six but all the way through age eleven as well (Ibid.).

For the authors, this is evidence that early deficits are attributable to severe deprivation in institutions and that the supportive family environment provided by adoptive families spurs cognitive catch-up. Unfortunately, for those children adopted from institutions after six months, cognitive deficits persisted into early adolescence. The same group remained significantly behind their non-institutionalized counterparts to age eleven (Beckett, Maughan, Rutter, et al. 2006).

In a related longitudinal study, Nelson et al. (2007) found that children randomly assigned to stay in residential care had significantly lower IQs compared with those assigned to foster families. Moreover, early placement in foster (family-centric) care remained predictive of more typical IQ scores over time. The earlier children are placed in family environments, the greater likelihood of more typical intellectual development in childhood.

In other domains—including memory, learning capacity, and executive function and self-regulation[3]—the evidence is also compelling. In a study by Pollak, Nelson and Schlaak et al. (2010), children with prolonged exposure to residential care performed significantly worse on exercises designed to test visual memory and attention, as well as "visually mediated learning and inhibitory control" (or the ability to resist natural impulses in order to complete a task successfully), than children in comparison groups. Broadly speaking, children with long-term residential care experiences were less able to focus, memorize visual cues, and complete tasks quickly, with clear negative implications for school and work performance.

Photo by Karen Kasmauski for CRS

Children deprived of family care experience more profound cognitive challenges than their peers who were either adopted at an early age, placed in foster families or raised by their parents.

Related studies include McDermott et al. (2012) who examined inhibitory control among eight-year-old children in each residential care, foster care, and among children who had never been in a care facility of any kind. The findings are complex, reflecting subtle patterns in brain behavior, but overall the children in residential care fared worse—making more errors, and completing tasks more slowly—suggesting "impaired neural processing," among other things, again with negative implications for school performance and possibly job training.

Loman et al. (2013) found very similar results to those of McDermott et al., while Merz et al. (2013) demonstrate worse outcomes in inhibitory control and working memory of children from facilities adopted after 14 months of age compared with those adopted before nine months of age and with those who were never institutionalized—highlighting, again, the more long-term complications of institutionalization on early childhood cognitive development as well as the benefits of removing children from residential care early.

More recent literature has continued to support the hypothesis that children deprived of family care experience more profound cognitive challenges than their peers that were either adopted at an early age, placed in foster families or raised by their parents (i.e., no placement in care). There does appear to be a gap in the research related to children who have been institutionalized and are subsequently reintegrated into their birth or extended family.

Recent studies explore a range of cognitive impairments and underdeveloped behavioral functions among children in residential care, including emotion regulation (Batki 2017), attachment[4]-related disturbances (Howard et al. 2017), and associative learning processes (Wismer Fries and Pollak 2016), among others. Finet et al. (2016) reviewed studies exploring the cognitive development of children in residential care versus family-based peers and early adoptees, and again they confirm the apparent negative effects of residential care on overall childhood development.

In sum, children with greater exposure (i.e., placed at an earlier age and staying for a longer period of time) to institutional care are susceptible to a spectrum of challenges that potentially inhibit learning and overall capacity to function at a high level in society.

Two positive findings also emerge, however. First, children removed from institutional settings early, even from those that are among the most depriving—emotionally and physically—demonstrate an ability

3 Executive function is especially crucial as it is a learned skill requiring the brain functions of memory, mental flexibility, and self-control, and therefore reflects, in part, early childhood development experiences. See the following for more information: https://developingchild.harvard.edu/resources/inbrief-executive-function/ (Accessed October 20, 2017).

4 Attachment refers to a child's coping mechanism, partly governed by neural pathways developed during infancy based on interactions with immediate caregivers, which negatively affects emotions including trust, empathy or affection. See: https://www.psychologytoday.com/basics/attachment (Accessed October 22, 2017).

Photo by David Snyder/CRS

Cheney and Rotabi (2015), who label the phenomenon as the "global orphanage industrial complex," argue that the presence and growth of orphanages has crowded out public financing for potentially more effective child social services, or has absolved governments of being more proactive in the protection of vulnerable children.

to catch up to peers across a range of cognitive and psychological indicators. Second, a nurturing family setting appears to significantly assist in this catch-up process, underscoring the ability of children to rebound from early setbacks.

PHYSICAL

The biomedical and developmental psychology literature increasingly reveal that cognitive and behavioral disorders arise, in part, from physical deprivation. As indicated above, underdeveloped brain circuitry and hormonal imbalances stemming from family deprivation manifest as learning and behavioral challenges (Pollak, Nelson and Schlaak et al. 2010).

Bauer et al. (2009), for example, used MRI to reveal volumetric differences between "previously-neglected" and "typically developing" children in areas of the brain[5] that corresponded with poor performance on memory and executive-function tasks. They confirm that brain growth and function are "plastic" and "experience dependent." In line with these findings, this section reviews literature that examines links between institutionalization and observable physical traits in children, again underscoring the negative association between long-term residential care and childhood well-being and healthy development.

Literature has consistently documented lower weight, height, and head circumference among children in institutionalized care (Van Ijzendoorn et al. 2007; Miller 2012). Originally, this was thought to be the result of nutritional deficiencies and elevated HIV infection rates in institutional settings, but the persistence of these results, even after controlling for disease and nutrition, have led researchers to reconsider drivers of physical stunting and consider the possibility that "children experience some amount of psychosocial growth suppression" from institutional care (Berens and Nelson 2015: 4). Stunting may therefore be the result of "stress-mediated suppression of the growth hormone/insulin-like growth factor 1(GF/IGF-1) *induced by the institutional environment"* (Ibid: 4, Johnson and Gunnar 2011; emphasis added).

Smaller head circumference, meanwhile, may be the result of "neural pruning" as a function of under-stimulation (Nelson et al. 2011; Sonuga-Barke, Beckett

5 Smaller superior-posterior cerebellar lobes among 31 adoptees from Eastern European and Russian institutions.

and Kreppner 2008). Several studies have replicated the relationship between institutional care and smaller head circumferences (Van Ijzendoorn et al. 2007, Johnson 2001; Sonuga-Barke, Schlotz and Rutter 2010; Johnson et al. 2010). Disconcertingly, although children placed in foster care demonstrated rebound in height and weight, head circumference remained stubbornly smaller (Johnson et al. 2010). Sonuga-Barke, Scholtz and Rutter (2010), for example, argue that even at age 15 years, reduced head circumference was *significantly and independently related to duration of stay in an institution* (emphasis added). What is clear so far is that young children require interaction and stimulation, for both mental and physical growth, and those are too often inadequate in long-term residential care settings.

With respect to height and weight more generally, the same authors demonstrate that height and weight catch-up was impeded if the child was removed from an institution after 12 months of age, compared with those removed earlier. Johnson (2001), estimates that children lose one month of linear growth for every two to three months spent in an institution.

Other, more recent studies, also suggest that a negative relationship between institutionalization and growth occurs (Reid et al. 2017, for example), while some emerging research probes the relationship between institutionalization and the central nervous system, including the hypothalamic-pituitary-adrenal "axis," or complex set of neural systems that regulates stress, with potentially negative implications for social development and adult behavior (*inter alia* Mclaughlin et al. 2015, Esposito et al. 2016, Vanderwert et al. 2016, Hevia-Orozco et al. 2017 and Koss et al. 2016). As before, the literature strongly suggests that children who are placed with families are most likely to rebound, cognitively and physically, and that this rebound is in part the result of human interaction and stimulation that every child requires and deserves.

SOCIAL

Physical and cognitive effects interact in complex ways with development which, in turn, has effects on school or job performance and comfort in group settings and socialization.

To date, much of the literature—the majority of which as noted before, we caution, are based on data from Central and Eastern Europe—has focused on the prevalence of attachment disorders among post-institutionalized children. As Berens and Nelson (2015) point out, myriad studies have recorded a preponderance of "insecure" or "disorganized" attachment and decreases in secure attachments, which can result in erratic and potentially dangerous behavior.

In children, specifically, insecure and disorganized attachment can manifest as intense fear of adults, and is most predictive of difficulties later in life. Additional studies suggesting a link between institutionalization and attachment disorders include inter alia Vorria et al. (2003), Román et al. (2012), Dobrova-Krol (2010) and O'Connor et al. (2003).

O'Connor et al. (2003), in particular, observed the prevalence of an attachment style labeled "insecure-other" among post-institutionalized children, which involves "atypical, non-normative, age-inappropriate behavior," including "extreme emotional over-exuberance" and "excessive playfulness with parent and stranger alike" (Berens and Nelson 2015: 7).

Rutter et al. (2007), in a follow-up study to their initial ERA work, found a clear link between insecure attachment, poor overall mental health, and even social services enrollment at later ages (six and 11 years old, specifically). Other insights from the study (Rutter et al. 2010) include the prevalence among children adopted after six months of age of what the authors label "institutional deprivation syndrome." This involves "a novel constellation of impairments including inattention or hyperactivity, cognitive delay, indiscriminate friendliness and quasi-autistic behaviors" (Berens and Nelson 2015: 7). These characteristics have potentially severe implications for building healthy relationships with peers, adopted parents and employers.

In a study involving children still in Romanian institutions, Ellis, Fisher and Zaharie (2004) record a link between duration of institutional stay, severe anxiety and affective disorder symptoms (more commonly referred to as "mood disorders"). Julian and McCall (2016) similarly observe better social skills among those adopted from "socially-emotionally depriving institutions" *before* 18 months of age compared with those adopted after this age, and Jiménez-Morago, León and Román (2015) demonstrate greater adversity and worse "psychological adjustment" among children in institutions versus peers in both foster care and international adoption.

These results shed light on real-world or everyday difficulties experienced by post-institutionalized children. More recent literature has begun to document the lingering effects of residential care stay on socialization, whether disinhibited social engagement disorder (DSED) (Lawler et al. 2016) or social decision-making, including when to trust others (Pitula et al. 2016).

Each of the above studies, in combination with the previous sections on physical and cognitive effects, paints a picture of children who face daunting obstacles. The degree of disabling fear, anxiety or social distrust has been routinely tied to the degree of exposure to institutions, versus family-based care or interaction with caring guardians or parents. However, each section also underscores how the more deleterious impacts of long-term residential care can be alleviated if children are removed from institutions early, and placed among families. These findings should inform the clear policy goal of moving toward family-centered care.

OTHER DIMENSIONS OF INSTITUTIONALIZED CHILD CARE

The works cited thus far have surveyed the influence of institutionalization on childhood development, broadly examined through the effects of long-term residential care on cognitive, physical, and social traits. This section reviews other elements of institutionalization more broadly before examining what works for families and children, and pathways forward.

ABUSE AND NEGLECT

While we caution against overgeneralization since evidence of abuse and neglect is sometimes anecdotal—and thus risks dismissing positive outcomes (Islam and Fulcher 2016)—there is compelling evidence that abuse and neglect are more common in residential care facilities than among the wider population (Sherr, Roberts and Gandhi 2017).

In 2017, Better Care Network published a discussion paper titled "Violence Against Children and Care in Africa." It reviews studies from across Africa, where the prevalence of abuse and violence against children in institutional care settings is staggering: In Tanzania, for example, 93% of children and 87% of caregivers report abuse by caregivers in one institution (Hermenau et al. 2015). Research from Morocco, meanwhile, reveals that physical violence is considered appropriate discipline in an institutional setting (AÐt Mansour 2006). And although it acknowledges significant strides towards reform, a Human Rights Watch report (2014) on Japanese childcare facilities (or "alternative care" in local parlance) observes a legacy of abuse and ongoing instances, as well as overcrowding and facility overuse.

Several studies provide additional evidence that children in residential care facilities are at greater risk of abuse than in a family setting. Euser et al. (2013), for example, use two different reporting methods to reveal a higher incidence of childhood sexual abuse in Dutch residential care than those in either foster care or the general population. A quasi-experimental study of abuse in Romanian institutions concludes that the probability of experiencing abuse, and its frequency, increases with the duration of stay at a facility. Moreover, the odds of severe punishment were far greater in a traditional residential care facility than in a family-centered or mixed type facility (Rus et al. 2013).

In an edited volume by Rus, Parris and Strativa (2017), data from diverse cases—including Spain, Turkey, Israel, Kenya, China and Russia—broadly draw similar conclusions: that abuse is more prevalent in long-term care facilities, and that a family-setting is far more conducive to protecting the rights and well-being of the child.

Scholars now recognize two types of violence against children—specifically 'commission' (violence is actively perpetrated) and 'omission' (the intentional withholding of care and attention, or neglect) (Sherr, Roberts and Gandhi 2017).

Van IJzendoorn et al. (2011) argue that what best characterizes what occurs in large institutional care settings is "structural neglect." Structural neglect is the reinforcing and overlapping presence of each infrastructure issues (particularly large-scale dormitory like settings), staffing patterns (i.e., shifts) and limited and inadequate interaction between children and staff, partly due to low caregiver-to-child ratios (Better Care Network 2017). As the previous section makes clear, inadequate stimulation and interaction between caregivers and children depresses healthy cognitive, physical and social development.

DISABILITIES AND RESIDENTIAL CARE

Along with poverty, a child's disability may be a driving factor behind placing him/her in residential care, while the care of children with disabilities in residential care facilities is frequently inadequate.

Disability Rights International (DRI), among others, have increasingly called for children with disabilities to be placed in a family setting, like any other child, citing a prevalence of abuse and neglect of disabled children in residential care, as well as the ratification by 174 countries of the UN Convention on the Rights of Persons with Disabilities, which closes a loophole in the UN Convention on the Rights of the Child (CRC) that allowed for so-called "suitable institutions" for the disabled to persist (Ahern 2017).


Photo by David Snyder/CRS

A burgeoning residential care industry, bolstered by donors who have shown preference for investing in residential care over alternatives, promotes and sustains institutionalization contra the evidence of its effect on children.

Despite this positive turn of events, DRI continues to catalogue the abuse and neglect of disabled children in institutions across 25 countries. They observed treatment they believe qualifies as torture by international standards, and neglect that not only deprives residents of stimulation, but puts their most basic health at risk (Larsson 2016). Human Rights Watch (2014b) has made similar observations, catalogued most specifically in a report on disabled children in Russian orphanages. The report underscores the lack of rehabilitative care, personal interaction, and poor sanitary conditions into which disabled children are forced. It also underscores how placing a child with a disability is widely perceived as a default and appropriate option, and how the stigmatization of disabilities pushes children into residential care.

Ultimately, it is at-risk or vulnerable youth—whether from conflict, poverty, a disability, or neglect—who are most susceptible to institutionalization, but whose vulnerability is only further compounded by institutionalization itself.

Finally, the cyclical nature of violence is another factor of concern. Children who have been abused have an increased likelihood to be perpetrators of violence and abuse as adults (Crombach and Bambonyé 2015; Better Care Network 2017). Governments and donors should want to prevent children from being exposed to this for the immediate and long-term negative effects and costs to society.

THE PULL FACTOR OF INSTITUTIONS

Despite the deleterious impacts on childhood health and well-being, as well as the prevalence of abuse, institutions have real "staying power." This section briefly explores the factors that make institutionalization the first response to vulnerable children in many contexts.

Better Care Network (2017) identifies push and pull factors that separate children from their families. Violence at home and coping with a child's disability or chronic disease are distinct push factors—increasing vulnerability and pushing children out of their homes and away from rehabilitative family care. In some cases, parents send their children to institutions so that they can obtain access to basic services such as education (Ibid.).

Pull factors, on the other hand, make it easier for parents or caregivers to send children to residential facilities, even if research and international child-rights instruments such as the CRC and the Guidelines for the Alternative Care of Children (United Nations 2009) make clear that placement in residential care should be based on the principles of necessity and appropriateness for the individual child. It should also be temporary in nature and if at all possible should be avoided for children under the age of three.

Residential care facilities, by themselves, constitute a pull factor (Evans 2011). Their presence, especially in resource-scarce contexts where social and rehabilitative services may not be available, "'pull' or 'recruit' children from vulnerable families into residential care" (Better Care Network 2017: 37). In three of the five countries surveyed for the Better Care Network report, respondents reported "recruitment by care center or 'pulling effect' of

residential care because they are present" as a reason for placing children in residential care (Ibid.).

Another pull factor is how some in the medical community, particularly where norms and attitudes towards disabilities have been slower to change, have encouraged institutionalization, even if unsuitable (Carter 2005). In one example, medical professionals encouraged a mom to "reject" her child with a disability and "send her to an institution" (UNICEF 2005, Better Care Network and UNICEF 2015: 61).

AN ORPHANAGE INDUSTRIAL COMPLEX

There is a burgeoning residential care industry which further promotes and sustains institutionalization, contra the evidence of its effect on children. Walakaria et al. (2017) note that boarding schools in Uganda present themselves to donors, including faith-based groups, as orphanages in order to secure private-sector and international funding. At least one report identifies a preference among donors, including international and local faith-based organizations, to invest in residential care versus alternatives based on perceptions of need (Firelight Foundation 2008). A study of attitudes among the UK public similarly revealed a strong preference for residential care and inter-country adoption in response to an emergency (Save the Children 2010).

More recently, Mulheir and Cavanaugh (2016) catalogue an orphanage industry in Haiti in which over 80 percent of children are not orphans, and where only 15 percent of orphanages are registered. The rest operate outside the law with opaque finances, and some purposefully engage in child human trafficking. The preponderance of "off-the-grid" institutions, like those in Haiti, inhibits oversight and regulation. In a 2007 survey, 137 of 488 surveyed orphanages in Sri Lanka were not registered with the state (Rocella 2008). In 2004 Zimbabwe, 67 orphanages failed to register, with 24 of those opening in the last ten years (Powell et al. 2004). Discouragingly, this phenomenon is "linked, in part, to the persistent funding of institutional care by private donors and faith-based organizations" (Better Care and UNICEF 2015: 57). It is also linked, according to Csáky (2009), to the recruitment of children by orphanages to service the demand of the international adoption industry.

Cheney and Rotabi (2015), who label the phenomenon as the "global orphanage industrial complex," argue that the presence and growth of orphanages has crowded out public financing for potentially more effective child social services, or has absolved governments of being more proactive in the protection of vulnerable children.

THE STAYING POWER OF ORPHANAGES:

Why does residential care continue to be the first response to vulnerable children around the world?

PUSH FACTORS
increase vulnerability and push children out of their homes and away from family care.

- Poverty is a key push factor. In some cases, parents send children to institutions so that they can obtain access to basic services such as education.[1]
- Children with disabilities are frequently misunderstood and stigmatized, or parents may not be able to adequately care for their disabled child, pushing them into residential care where their needs frequently remain unmet.

PULL FACTORS
make it easier for parents or caregivers to send children to an orphanage.

- Even knowledge of the presence of an orphanage, especially in resource-scarce contexts where social and rehabilitative services may not be available, can "pull" or recruit children from vulnerable families..
- Some in the medical community encourage orphanage care, particularly where norms and attitudes toward disabilities have been slower to change.

WAYS FORWARD: FAMILY AND COMMUNITY BASED CARE

A bright spot presented throughout the literature is that children removed from residential care have proven remarkably resilient with respect to social and physical catch-up, which further underscores the urgency of moving children from institutions to nurturing family or community care settings (Berens and Nelson 2015: 8). Schoenmaker et al. (2014) argue that, based on a review of multiple studies, including the Leiden Longitudinal Adoption study, stable family environments have a direct bearing on the well-being of children into adulthood, and that adoption is a viable intervention for children in institutions.

Reunification with parents or placing children in supportive family settings is highly effective at reversing harm and rehabilitating children into healthy, vibrant young adults.

Fluke et al. (2012) reviewed disparate literature and concluded that, despite some diversity among results, protective services should attempt permanent family care however possible. Boothby et al. (2012) acknowledge a weakness in the extant research on the topic as well, but similarly conclude that family tracing and reunification is highly effective with respect to separated children, while institutionalization is problematic. These studies, combined with the collective insights discussed above, make the case for de-institutionalization clear.

UN GUIDELINES

However, closing facilities without proper alternatives, clear and costed plans to support all aspects of a reform process or transitional guidelines could be even more detrimental to child well-being in the short-term (Frimpong-Manso 2014; Messer et al. 2015; Whetten 2009; Davidson et al. 2017). In 2009, the UN General Assembly endorsed the *Guidelines for the Alternative Care of Children* (Guidelines hereafter) in order to encourage States to reform and increase accountability and to guide a transition systems of child protection from residential care to increased family-based care based on recognized best practices.

The two main principles that the Guidelines are based on, necessity and appropriateness, make it clear that there are a range of care options that should be made available to children in need of care (while which type of care is determined by the needs of the individual child and should always be made in his or her best interest). The Guidelines, in fact, provide the most current foundation, and child-rights based framework, for care reform. While limited by way of enforcement, they are nevertheless the greatest global instrument that the sector has in terms of clearly outlining how and when alternative care should be provided (Save the Children 2012).

One of the key points of the Guidelines is that poverty should never be justification for separating a child from his/her family. This is hugely important in terms of identifying the main reason why children are placed in residential care in most African contexts, for example.

Based on the framework delineated by the Guidelines, the current approach to de-institutionalization is multi-faceted: prevent, whenever possible, new, unnecessary admissions to institutions through the provision of accessible family support services; establish proper gatekeeping mechanisms (discussed more below); prioritize placement in family-based

alternative care settings (kinship, foster, independent living) if biological parents and extended family are unable to care for the child; promote and support safe reintegration of children currently residing in residential care.

SOCIAL SERVICES

Within this broad framework, Save the Children UK (2009) recommends, among other interventions, more robust social services, which need not necessarily be a bureaucratic endeavor. As one example, conditional cash transfers have proven effective in augmenting child care and reducing child mortality (Yablonski and O'Donnell 2009; Yablonksi and Bell 2009), while a UNICEF study concluded that social protection schemes in southern Africa—including cash transfers, school fee support and grants for elderly caregivers—reduced the need for alternative care and assisted relatives caring for children whose parents could not (Dunn and Parry-Williams 2008).

Better Care Network and the Global Social Service Workforce Alliance (2015) present case studies from Moldova, Indonesia and Rwanda, exploring each country's experience with social services reform and capacity building. In 2007 Moldova had proportionally more children in residential care than any other country in the region. A combination of concerted reform and workforce development—as well as innovations in combining formal and informal systems of community-based social services—had drastically reduced the number of children in residential care. With the assistance of international donors, NGOs and the State were able to develop a robust network of child protective services that included a corps of professionally-trained social workers that had previously not existed under the former Soviet state system. One innovation in Moldova was the role of children themselves, including some who formerly lived in residential care, who assisted in interviewing children now placed in foster care and subsequently made recommendations to regional governments on service improvements.

In Indonesia, research conducted in 2006 by the State's own Ministry of Social Affairs, in partnership with UNICEF and Save the Children, revealed that the country's child protection services relied overwhelmingly on residential care, with 500,000 children housed among an estimated 8,000 unregulated institutions (Martin and Sudrajat 2007).

RESILIENCY OF CHILDREN

When removed from residential care, children demonstrate an extraordinary ability to rebound from early challenges to become healthy, vibrant young adults.

These results spurred a rethinking of child protective services and in part led to the development of a national registry of residential care facilities as well as the 2011 National Standards of Care for Child Welfare Institutions which included guidance on social service workforce development (Ibid.).

Indonesia's complex geography, highly decentralized government and limited number of trained social workers slowed concrete progress, initially, but local innovations again helped spur significant change. Specifically, care reform relied on input and implementation by a wide array of stakeholders. The local faith community, including Muhammadiyah—an important Islamic organization committed to social and educational improvement but also one of the largest provider of residential care in the country—was central in each research, the development of new policies and standards, and changes in how its own social workers worked with families (Ibid.). Local governments, local partners and donors have also

spearheaded social service innovations including non-residential based support services at facilities that both assist families, and provide on-site training for new social workers (Ibid.).

In Rwanda, the genocide resulted in a surge of children placed in residential care. In 2012, according to the National Survey of Institutions for Children in Rwanda, there were 3,323 children, youth, and adults living in 33 institutions, with 70% reporting that they had at least one parent or living relative. Most children, in fact, were being referred to institutions by their parents, relatives, or local authorities, and mostly because of poverty (Ibid.).

POVERTY SHOULD NEVER BE JUSTIFICATION FOR SEPARATING A CHILD FROM HIS/HER FAMILY.

The Better Care Network and Global Social Service Workforce Alliance report (2015) lauds the the Rwandan government for its reform efforts, however, with a demonstrable commitment to both an enhanced legal framework as well investments in childhood protective services. Central to the reform process, the government and NGOs focused on strengthening traditional mechanisms of protection at the community level. Another local innovation was to attempt to transform, rather than replace, the role of residential care facilities themselves. The report cites one example in which a residential care facility's staff was trained in counselling and assisted in a program that provides baby formula and porridge to families in an effort to keep children with their families that, without the assistance, may have been unable to afford for their care.

In the absence of adequate services, however, even well-intentioned organizations and responsible parties are faced with limited options, and children are returned to institutions against recommendations and better judgment (Bilson and Larkins 2013, Every Child 2009).

GATEKEEPING

In the effort to move away from institutionalization, one tactic has been to attempt to provide a suite of services and resources that keep children, the majority of which have one or more parent or available extended family, out of institutions in the first place. This has been referred to as "gatekeeping," and has proven successful in different contexts: Bilson and Larkins (2013) explore the mixed effects of gatekeeping in Bulgaria, while Save the Children (2009) profile a system of wrap-around services in Croatia that has assisted in the larger effort of keeping children out of institutions.

Better Care Network, in concert with UNICEF (2015), examine five diverse cases of gatekeeping in each Moldova, Rwanda, Brazil, Bulgaria, and Indonesia. One conclusion from the report is that there is no single model of gatekeeping that works best, and that it can be institutionalized differently—and still be effective—across different contexts. Common denominators of successful gatekeeping, instead, consist of a political commitment, adequate resources, diverse and adequate services as well as an element of standardization and protocols.

In an important first step, countries have made considerable headway in establishing legal frameworks (Better Care Network and UNICEF 2015: 51). Each of the countries in the Better Care Network and UNICEF study, along with others including Ghana, Liberia, Malaysia, and the European Union, have adopted legislation that take cues from the UN Guidelines and encourage a family-centric approach to child protection and well-being. Some countries are more effective than others in implementing gatekeeping, however.

In the best cases, for example, countries have established panels or courts that coordinate services efficiently and facilitate gatekeeping and child-first action, avoiding over-institutionalization in the process (Wulczyn et al. 2010; World Vision 2011; Wessels 2012). Other countries struggle, including Botswana (UNICEF 2011a), Cambodia (Andrew 2008, UNICEF 2011b), and Ghana (Child Frontiers 2011, Frimpong-Manso 2014)—grappling as they are with limited resources, complex geographies, and tension between Western norms embedded in the Guidelines and local contexts (Davidson et al. 2017, Bilson and Westwood 2012, Islam and Fulcher 2016).

The evidence is overwhelming that long-term residential care poses a significant risk to the health and well-being of children, with similarly large implications for society and public policy as children mature out of institutions and transition into adulthood.

Resources aside, a final frontier in making progress in gatekeeping, and deinstitutionalization more generally, is the changing of perceptions, norms, and behavior. As has been previously discussed, there is a perception among private donors, charitable and faith-based organizations, the general public, and even medical professionals and welfare staff in certain contexts, that institutionalization is the best option for children with disabilities or otherwise separated from a parent (Better Care Network and UNICEF 2015, UNICEF 2007).

There has been progress, however, as legislative reform in places as diverse as Cambodia, Brazil, and Moldova demonstrate and evolution in thinking among leadership and the political class. That said, there is too often a gulf between passing legislation, and implementation, and myriad factors—from an international adoption demand, and even "industry," to a simple lack of alternatives—stymies more progressive deinstitutionalization despite its demonstrably negative impact on childhood well-being.

CARE LEAVERS

Finally, as briefly alluded to above in the Moldova case, where children who had previously stayed in long-term residential care facilities but now live independently—also known as care leavers—now assist with social service policy recommendations, there is a role of children in shaping better outcomes. But care leavers also need our support.

As this report has consistently demonstrated, children in residential care face significant obstacles compared to family-based peers, but have also proven their dynamic resiliency. Stories from care leavers demonstrate challenges as well as a remarkable ability to persevere (Law 2014; Stein 2005).

Research nevertheless demonstrates that systems that help young people transitioning from residential care—like robust mental health services for instance—are hugely advantageous (Barnardo's 2014; Smith 2017). Other reforms that better position care leavers to thrive in society as young adults include specific assistance for transitioning to independent living, legal assistance and facilitating access to case records, job training, assistance in building social networks and counseling that helps care leavers avoid the criminal justice system (The Care Leaver's Association 2017). These support systems are still developing in industrialized countries, but may be absent altogether in more resource-scarce settings.

CONCLUSIONS

There will likely always be the need for short-term, high quality residential care for children who don't have safe and nurturing family-type options. But this should be the exception. The evidence is overwhelming that long-term residential care poses a significant risk to the health and well-being of children, with similarly large implications for society and public policy as children mature out of institutions and transition into adulthood.

In addition to the UN Guidelines, global, regional and national legal and policy frameworks may already provide impetus for hastened deinstitutionalization and early intervention for the best of the child. The UN Convention on the Rights of the Child (CRC), for instance, which entered into force in 1989 and which is endorsed by nearly all countries, calls for adoption "in the best interest of the child" and the protection of children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation." Article 25 demands a periodic review of the care provided children, along with "all other circumstances relevant to his or her placement by "competent authorities." It also explicitly recognizes that a child "should grow up in a family environment" for her "full and harmonious development." The UN Convention on the Rights of Persons with Disabilities reinforces the CRC and strengthens it, discarding the notion that any institution is permissible, and forcefully calling for family unification however possible. Additionally, under Goal 16 of the Sustainable Development Goals (SDGs), Target 16.2 aims to "end abuse, exploitation, trafficking, and all forms of violence and torture against children."[6]

Despite such declarations, and despite our deepening knowledge, however, an array of drivers including poverty, conflict, economic transition, the legacy of state systems, and even misguided good intentions on the part of donors or faith-based organizations have resulted in millions of children worldwide in institutions where the vast majority will remain until young adulthood. As the literature demonstrates, moving forward will require evolving social contracts that acknowledge local contexts, mores, and norms, while irrevocably moving in the direction of family or community-based care, for child and society. Crucially, it will also take States recognizing their mandate to provide essential social services to vulnerable families as well as family-based alternatives when children are separated from their parents.

6 http://indicators.report/targets/16-2/

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